title 31, United States Code, or deemed accepted by the Senate or the House of Representatives pursuant to Rule XXXV of the Standing Rules of the Senate or clause 4 of Rule XLIII of the Rules of the House of Representatives shall be reported as required by such statute or rule and need not be reported under this section.''.

(b) REPEAL OF OBSOLETE PROVISION.—Section 901 of the Ethics Reform Act of 1989 (2 U.S.C. 31–2) is repealed.

(c) SENATE PROVISIONS.—

(1) AUTHORITY OF THE COMMITTEE ON RULES AND ADMINISTRATION.—The Senate Committee on Rules and Administration, on behalf of the Senate, may accept gifts provided they do not involve any duty, burden, or condition, or are not made dependent upon some future performance by the United States. The Committee on Rules and Administration is authorized to promulgate regulations to carry out this section.

(2) FOOD, REFRESHMENTS, AND ENTERTAINMENT.—The rules on acceptance of food, refreshments, and entertainment provided to a Member of the Senate or an employee of such a Member in the Member's home State before the adoption of reasonable limitations by the Committee on Rules and Administration shall be the rules in effect on the day before the effective date of this subtitle.

(d) HOUSE PROVISION.—The rules on acceptance of food, refreshments, and entertainment provided to a Member of the House of Representatives or an employee of such a Member in the Member's home State before the adoption of reasonable limitations by the Committee on Standards of Official Conduct shall be the rules in effect on the day before the effective date of this subtitle.

SEC. ___05. EXERCISE OF CONGRESSIONAL RULEMAKING POWERS.

Sections 201, 202, 203(c), and 203(d) of this subtitle are enacted by Congress—

(1) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and pursuant to section 7353(b)(1) of title 5, United States Code, and accordingly, they shall be considered as part of the rules of each House, respectively, or of the House to which they specifically apply, and such rules shall supersede other rules only to the extent that they are inconsistent therewith; and

(2) with full recognition of the constitutional right of either House to change such rules (insofar as they relate to that House) at any time and in the same manner and to the same extent as in the case of any other rule of that House.

SEC. ___06. EFFECTIVE DATE.

This subtitle and the amendments made by this subtitle shall take effect on May 31, 1995.

FORD (AND FEINGOLD) AMENDMENT NO. 4

Mr. FORD (for himself and Mrs. FEINGOLD) proposed an amendment to the bill S. 2, supra; as follows:

At the appropriate place, insert the following:

SEC. . USE OF FREQUENT FLYER MILES.

(A) LIMITATION ON THE USE OF TRAVEL AWARDS.—Notwithstanding any other provision of law, or any rule, regulation, or other authority, any travel award that accrues by reason of official travel of a Member, officer, or employee of the Senate or House of Representatives shall be considered the property of the Government and may not be converted to personal use.

(b) REGULATION.—The Committee on House Oversight of the House of Representatives and the Committee on Rules and Administration of the Senate shall have authority to prescribe regulations to carry out this section.

(c) DEFINITIONS.—As used in this section—

(1) the term ''travel award'' means any frequent flyer, free, or discounted travel, or other travel benefit, whether awarded by coupon, membership, or otherwise; and

(2) the term ''official travel'' means travel engaged in the course of official business of the House of Representative and the Senate.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on Thursday, January 5, 1995, to conduct a hearing to examine issues involving municipal, corporate, and individual investors in derivative products and the use of highly leveraged investment strategies.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. GRASSLEY. Mr. President, I ask unanimous consent on behalf of the Governmental Affairs Committee (jointly with the Senate Budget Committee) for authority to meet on Thursday, January 5, for a hearing on S. 1, Unfunded Mandates.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Committee on Judiciary be authorized to meet during the session of the Senate on Thursday, January 5, 1995, at 10 a.m. to hold a hearing on the balanced budget amendment to the Constitution.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADDITIONAL STATEMENTS

AN INTERVIEW WITH QUENTIN D. YOUNG

● Mr. SIMON. Mr. President, one of the people who has been calling for justice in the field of health care in this Nation for many years is Dr. Quentin Young.

Recently, he was interviewed by the Christian Century, and that interview was published. It contains so much common sense that I hope some of my colleagues will read what he has to say.

I ask to insert his comments at the end of my remarks.

A person does not have to agree with everything that he mentions in his interview to recognize that we should be doing much better and that our friends in Canada are doing much better.

My conversations with Canadian Members of Parliament suggest that there are some improvements that we could make on the Canadian system, if we were to adopt a similar system. To suggest, as have so many in our country, that the Canadian system is a failure, is an outright falsehood. It is of interest that not a single Canadian Member of Parliament has introduced legislation to repeal the Canadian system.

The article follows:

HEALTH REFORM AND CIVIC SURVIVAL: AN INTERVIEW WITH QUENTIN D. YOUNG

(Since his days as a medical student at Cook County Hospital in Chicago, Dr. Quentin D. Young has been engaged professionally and politically in issues of public health. Currently clinical professor of preventive medicine at the University of Illinois Medical Center in Chicago, Young is also national president of Physicians for a National Health Program. He has been a leading and tireless spokesman for health care reform. We spoke with him recently about the fate of the Clinton health care proposal and the alternative of a single-payer insurance system like Canada's.)

A year ago many people had high hopes for health care reform. It was at the top of President Clinton's agenda and it seemed to have widespread public support. Now the issue is dead, and perhaps a crucial political opportunity has been lost. What went wrong?

President Clinton produced an enormously complicated proposal, which left him vulnerable to attacks from across the spectrum. Those of us who support a single-payer plan thought that if the reform had been enacted the way he proposed, it would have been a dreadful disappointment and a step backward. By going the route he did, he was forced to rely on the whole insurance infrastructure and a real nightmare of managed competition. All these huge bureaus he proposed—they invited ridicule and defeat. From his public and private comments it is clear that he understands the redundancy and the parasitic role of the insurance industry: it adds nothing to the product and subtracts mightily. (Basically insurance agencies and conglomerates are in the business of finding reasons not to give care.) So in light of that, his proposal showed a lack of courage. Another form of cowardice was that he didn't come right out and call his mandated premium—which had all the force of law—a tax. So that's the President's contribution to the failure of reform.

The decisive factor was the appalling undermining of the democratic process that took place in Congress. At least $150 million were spent on lobbying, on polls, on onslaughts from small business groups and others. In the face of this pressure, Congress became impotent. I think that viewing this activity intensified people's dislike of the political process. And I also think that there's a little bit of concern by those involved that perhaps the lobbyists engaged in overkill—that they created a sense of futility among the public. And power elites usually don't like to see a sense of futility among the public. Nor is it wholesome from the point of view of a reformer.

The conventional wisdom was—probably still is—that a single-payer plan is politically unfeasible.

Well, the route Clinton tried was politically unfeasible. His proposal couldn't have done any worse than it did. And winning isn't the whole thing. The big changes that have occurred in American politics—the abolition of slavery, the adoption of unemployment insurance and social security—did not happen in one swift action. There was a buildup of popular pressure and finally a breakthrough.

A battle over a single-payer plan would have clearly defined the issues, as is happening in the debate over the referendum on universal coverage in California. They are having a huge David-and-Goliath fight against the same forces that defeated the Clinton plan, because those forces know that if California should miraculously pass such legislation, then the game is over. In Canada in 1967 Saskatchewan passed health insurance legislation, and two years later Alberta did. In '71 the Tory Parliament in Ottawa voted unanimously for Medicare, which is what they call their national single-payer system. And, of course, the rest is history.

It's clear that you regard Canadian experience as a success story.

Canada has a humane, fair, extremely popular system. It does better than we do in longevity and infant mortality and most other health indices. Its achievement in cost containment is very simply summarized. Twenty-three years ago, before Canada initiated its reform, the U.S. and Canada were both spending 7.1 percent of their respective GDPs on health care. Now Canada's spending has risen to 9.5 percent—not a tiny rise, but nothing like our rise to about 15 or 16 percent, with no end in sight.

Whenever we talk about implementing a single-payer plan like Canada's that aims both to offer universal coverage and to cut costs, don't we have to talk also about putting limits on services? And that's what scares people. We don't like the thought of needing a heart bypass operation and being 315th on the list.

There has been an inordinate amount of Canada-bashing and exploitation of fear on this topic. The short answer is that that kind of denial of care can't possibly happen in the short run. We're spending about a trillion dollars per year now on health care, and the figure is rising. That's a per capita expenditure that's 40 percent higher than Canada's—so in terms of funding we would have 40 percent more available if we were to adopt their system. If you suddenly were to give the Canadian system a thousand dollars more per capita, then any problems of rationing would be solved.

In the U.S. under single-payer you'd immediately get a minimum of $100 billion available for health care by eliminating the waste in the insurance system. That's what Canada experienced when it initiated its reform. Canadians used to devote 11 percent of health costs to health insurance administration—which is what we spend. Now Canada spends less than 1 percent on insurance administration.

Add to that the benefits of negotiated fees with doctors. Many billions of dollars are truly squandered on excessive fees, breathtaking fees—a half hour's work is rewarded with $2,000 or $4,000. That's ridiculous.

The problems of the Canadian system, compared to ours, are trivial. More to the point, whatever problems it has involve a relative shortage in the area of high technology. That's precisely the area in which we have too much—literally too much equipment and too many specialists. This is a burden on the system. No reform will work until we rectify this problem: 75 to 80 percent of our physicians are specialists, only 20 to 25 percent are in primary care. The ratio should be 50–50, possibly 60–40 primary care. Those are the kinds of problems the marketplace gives us. Specialties offer the higher rewards.

A third source of savings with single-payer is that you could really control the laissez-faire medicine that is supposedly controlled by managed competition. I'm speaking, for example, about unnecessary surgery. About a third of hysterectomies performed in the U.S. were unneeded. There's thousands of dollars and harm to patients that could be saved. We're doing twice as many Caesareans as needed. At least 20 percent of coronary bypasses shouldn't have been done. So I don't think we have to ration yet if we eliminate these problems.

In the year 2010 it may be different. People are living longer. There is no question about the correlation of age with medical utilization. And scientists keep coming up with more and more complicated things that we can do to help people, which always adds big costs. But on the other end of the spectrum, you wouldn't have to treat some people at all because you've immunized all the kids and you will have early detection of breast cancer, and so on.

One often hears reports that wealthy Canadians come to the U.S. for treatment—the implication being that care here is quicker and better.

I'm sure Canadians went to the Mayo Clinic and to Johns Hopkins before there was mass health reform and they probably do now. Many Americans are going to Canada for care. But the crucial thing is that 99 percent of the health care the Canadians receive is under the system, which maintains high standards of research and training.

One of the very important characteristics of single-payer as it's played out in Canada, which I concede is due to its parliamentary system of government, is the fact that every week in each of the provinces and in Ottawa the minister of health has to face questions and complaints—''Mrs. Jones spent six hours in the emergency room'' and so on.

Also, it is illegal in Canada, as it would need to be under single-payer legislation here, for a private insurer to offer a benefit that is covered under the plan. If you allow that, you begin to undermine the system. You have to have everybody in it—particularly the elites. They will guarantee the product. They will see that by and large there's equity, there's high quality, there's a way to correct incompetence.

This point came home to me when I was on a radio show with an Anglican archbishop from Canada. He talked about the danger of Canada's being torn apart by the Anglophile-Francophile issue, and how a survey was conducted to see what makes Canadians feel patriotic, what brings them together in the midst of division. And way up at the top in the poll, for Canadians of all stripes—including those in Quebec—was the national health system. Here's a civic adventure that has brought people together. Compare that to the U.S. system of tooth and claw, of fear and bankruptcy and denial.

One of the reasons physicians and patients in the U.S. are wary about government-run health insurance is that they suspect it will mean an unreasonable limit on physicians' autonomy.

One of the benefits of single-payer is that, with everything going through the same computer, as it were, you can easily create a physician profile, noting frequency and interval of patient visits, number of ECGs prescribed, and so on. With this profile you can easily begin to see the doctor who is off the charts—who's doing three times the average number of ECGs, for example. That's a place to look for saving resources without oppressing physicians.

U.S. doctors already face scrutiny, but of a different kind: we doctors have an insurance person at the other end of the line from whom we have to get permission to practice medicine. Sometimes the line is busy, sometimes you're put on hold, and finally when you talk to the person she needs to have you spell the diagnosis that you're getting permission to treat. Not a happy scene. Do that three or four times in an afternoon and you wonder why you went into machine.

The insurance system has transformed doctors into technicians and given them some incredible restrictions. HMOs sometimes forbid doctors from discussing treatment options that aren't available under the plan. That violates the principle of informed consent, central to any real patient-doctor relationship.

I can give myself as an example of the need for appropriate scrutiny. I was trained at Cook County Hospital in the late 1940s and '50s when one-third of the hospital beds were dedicated to TB. We used to do X-rays on these patients every week—it was the only guide to how someone was doing. And it became an article of faith that one had to do a chest X-ray of every new patient, certainly of every over-40 urban dweller. About five years ago a younger colleague told me that there's no medical justification for doing this. Routine chest X-rays of people who have no symptoms are simply not an effective diagnostic tool anymore. I was acting out of my experience and training. But my old-fashioned approach had ceased to be good medicine.

You mentioned your own medical training. As you look back, do you recall any particular experience that galvanized your concern for reforming the way health care is delivered?

Well, certainly training at Cook County was part of it. It's a big public hospital that deals with an endless sea of patients—1,500 a day come through the doors in every state of malady: end-stage Alzheimer's, gunshot wounds, bad colds, gallbladder problems, cancer. Whatever there was, County had. And you see the most disenfranchised, the most impoverished, the wretched of the earth. I was just a middle-class, kind of liberal person, but it became clear that a doctor at County could adopt one of two philosophies—and the staff was about evenly divided along these lines. About half the doctors felt that they were witnessing divine justice, a heavenly—or Darwinian—retribution for evil ways, for excesses in drugs, in booze and everything else. Patients came to the hospital with their breath laden with alcohol, with needle marks on their arms, their babies illegitimate and all the rest. The other half decided that here was the congealed oppression of our society—people whose skin color, economic position, place of birth, family size, you name it—operated to give them a very short stick. When you saw them medically and psychologically in that broken, oppressed state, it was clear that you had to address issues of justice, not just medical treatment.

I had to decide which of these value systems was fair and just, and which one I could live with. It seemed to me the first approach is judgmental and harsh and simplistic. Taking the alternative view gave me a shot at being a part of the human race. And taking that view also accounts for my optimism. While we are not a noble species, I've seen evidence that when people are given the opportunity they can be very noble. People get bigger than themselves, take risks, are altruistic. I've been privileged to be in a few of those moments, like the civil rights movement. That little kernel of altruism, which may account for .002 percent of everyday behavior, at times expands to be 100 percent for that day, or that week. My notion, both as a doctor and as a citizen, is that you have to expand that altruistic fraction.

When we interviewed former Surgeon General C. Everett Koop about health reform, he said at one point that a central issue is the simple question, ''Am I my brother's keeper?'' Is it fair to say the American public, or a large section of it, has basically said no to that question?

It's not fair to say that. The polls keep saying that Americans want universal care. They even say health care is a human right, which of course it isn't. It is, at best, an implied right the way privacy is.

There's a dialectic to being one's brother's keeper. It isn't simply, ''Christ asserted it and therefore it's right.'' It's a living thing. I don't have the credentials to be theological, but I do think that the act of taking care of everybody in our health care system will make us our brother's keeper. It will emancipate us to attack the other enormous problems that we must solve. We can't have people hungry every night. We can't have children uneducated. But we do. We have to stop that. We won't survive otherwise. And nowhere is it written that every society survives. It's written somewhere that they all perish. And we've got all the credentials to go down the road to oblivion—not tomorrow or the next day, but not necessarily very much later. Time is running out.

You are putting health care reform in the context of a much larger moral crisis.

I do see health care reform as crucial to national civic survival. Consider some of the huge problems we have: air pollution, waste disposal, failed schools, homelessness, crime in the streets, hunger. The common denominator is that there are no resources available to solve these problems beyond what's already out there. Then consider health care, which is the biggest problem, and one that affects everybody. Homelessness affects those who have to live around the homeless, and it affects some sensitive people, but otherwise the problem belongs to the people who are homeless—and so on with all the problems I mentioned. But when you get to health, it's everybody's problem—if not today, then tomorrow. And it's the only social problem that we can fix using the resources—manpower, facilities, expenditures—we already have in place.

I don't want to be apocalyptic, but I think the case can be made in terms of the national mood—the polarization, the hate, the despair, the dissatisfaction with the political process—that health care reform offers us our last best chance to restore a sense of civic life and civic responsibility.●

COSPONSORSHIP OF THE BASEBALL PRESERVATION ACT

● Mr. GRAHAM. Mr. President, I lend my support to the National Pastime Preservation Act submitted to the new Congress by Senator DANIEL PATRICK MOYNIHAN and cosponsored by Senator JOHN WARNER.

Once again, Major League Baseball has shown that it does not warrant an exemption from our antitrust laws. Our national pastime has been silenced, with little or no immediate prospect of a resumption in play.

Mr. President, today is perhaps the coldest day of the winter so far this season. On these chilly days, our Nation should be on the verge of anticipating the annual ritual that signals hope of warmer weather on the way; the crack of bats at spring training.

But spring training could be lost. The possibility—which would compound the loss of part of the 1994 regular season and the World Series—underscores the urgency of prompt consideration of the National Pastime Preservation Act.

For Florida, the loss of spring training would result in an estimated loss in tourism dollars of at least $350 million, perhaps $1 billion. In the last several years, communities in Florida have made substantial investments in new and upgraded training facilities for the very clubs that will not be able to play.

This crisis has hurt Florida and America. Clearly, it is time to subject Major League Baseball to the same laws of competition that apply to the rest of business in our country. No other professional sport has an antitrust exemption.

Major League Baseball has used it antitrust exemption to prevent franchise migration to areas more willing to support teams. A consequence of this failure to allow the market to determine franchise location is a wide disparity between franchises. This, in turn, had led to the revenue-sharing proposal to be financed by a ceiling on players' salaries. Thus, the issue which is at the heart of the current controversy—a ceiling on players' salaries—is attributable to a misuse of the antitrust exemption. Additionally, removal of the antitrust exemption would be an incentive to the players to go back to work and continue negotiations.

I urge my colleagues—in the name of restoring our national pastime—to consider and support the legislation to remove baseball's antitrust exemption.●

SPEECH BY U.S. AMBASSADOR TO ARMENIA

● Mr. SIMON. Mr. President, recently, I read in the news of the Armenian General Benevolent Union, a speech by Ambassador Harry Gilmore, the U.S. Ambassador to Armenia.

Because it has insights into the problems faced in Armenia, I am asking to insert it into the CONGRESSIONAL RECORD at the end of these brief remarks.

The United States must exert every effort to see that Armenia and her neighbors, Turkey and Azerbaijan, can live together in peace.

This is in the best interests of Armenia and is in the best interests of Turkey and Azerbaijan.

But there are emotional barriers to achieving this.

While those emotional barriers remain, the people of Armenia struggle.

This speech was given in Los Angeles, on June 14, 1994, to guests attending a fundraising banquet for the American University of Armenia, which I have had the privilege of visiting in Armenia.

The speech follows:

HARRY GILMORE—UNITED STATES AMBASSADOR TO THE REPUBLIC OF ARMENIA

Distinguished friends and guests of the American University of Armenia, I bring you a story tonight of darkness and light. The darkness you know. Armenia is going through perhaps the most difficult period it has endured since the end of first Republic of Armenia in 1920. The people of Armenia have been living without heat and light, beset by war and economic hardship. But in the middle of the darkness there are some islands of light—and one of those is the American University of Armenia.

Tonight I want to tell you some of my experiences as the first Ambassador of the United States to the Republic of Armenia. I want to tell you something about what the United States Government is doing in Armenia. And I want to tell you why I believe in the future of Armenia.

Our Embassy in Yerevan, the first foreign Embassy in Armenia, opened in February 1992, in the Hrazdan Hotel. Now we are in the building that once was home of the Young Communist League. We have about fifteen Americans working in our Embassy from the Department of State, USAID, USIA, and the Peace Corps, and about sixty Armenian employees. Plus there are 25 Peace Corps Volunteers in Armenia, with more to come in July.

As you may know, in August 1992 I was first nominated to be Ambassador by President Bush. After the 1992 elections, President Clinton re-nominated me. I was finally confirmed by the Senate in May 1993. I arrived in Yerevan with my wife Carol that same month, one year ago.

I found our diplomats in Yerevan were living, much like the residents of Yerevan, frequently without electricity, heat, or water. There was, and often still is, only about one or two hours of electricity each day. During the first winter, our diplomats often wrote their cables by the light of butane lanterns. One diplomat found that his laptop computer wouldn't start unless he heated it up first on top of his wood stove.

Now we are fortunate to have generators and kerosene heaters in our homes and at the Embassy. Most Armenians are not so lucky. Nuclear physicists are working by candlelight. A factory that used to produce microprocessors is making kerosene stoves. One daily newspaper, The Voice of Armenia is being printed on ice-cream wrapping paper. The winter before I arrived, the temperature inside school classrooms was often below freezing. Some classes consisted of little more than jumping up and down to stay warm.

I decided from the beginning that our Embassy should have three goals: first, to help Armenia survive, emphasizing humanitarian assistance; second, to try to help Armenia achieve peace, and an end to its economic isolation; and third, to help Armenia build a democratic government and new free market economy that will allow Armenians to control their own destiny, and guarantee their own future.

HELPING ARMENIA SURVIVE: HUMANITARIAN ASSISTANCE

Our first job has been to help provide humanitarian aid, so Armenia can survive the economic crises caused by the collapse of the Soviet Union and the war. The Armenian-American community, the Armenian Church and other private donor organizations have been extremely active in these efforts. Soon after the Embassy opened, the U.S. Agency for International Development located its regional office for the Caucasus in Yerevan, and our government got involved in a major way.

Much of our time has been taken up by the logistics of getting wheat and fuel moving to Armenia. I now know more about the Georgian railway system than I ever wanted to know. When U.S. government wheat was stranded in Batumi, in Georgia, because there was no electricity to run the Georgian railways, we chartered diesel locomotives, and provided fuel for them. When there was a shortage of wheat in Armenia, because the trains in Georgia weren't running, we obtained money to buy kerosene and diesel fuel to trade to the Armenian farmers for wheat.